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ABSTRACT

This presentation describes a home visiting health education program serving Mexican and Mexican-American migrant farmworkers in Florida. The purposes of the program were to educate farmworker families about pregnancy, childbirth, nutrition, and child development, and to encourage the use of preventive health care services. Home visitors were recruited from the migrant population and received training in health care and child development. Results from a program evaluation showed that the program had a positive impact on the health behaviors of the families involved. (PCB)

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Fair Start Program
Outreach to Mexican and Mexican American Farmworker Families

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The Fair Start Program, a home-visiting health education project, served a unique and often forgotten population: Mexican and Mexican American migrant farmworkers. Designed to improve maternal and infant health, the program was sponsored by the Martin Luther King Clinica Campesina, a federally-funded clinic in Homestead, Florida. Program staff helped families gain access to health care services, promoted sound health self-care prenatally and during infancy, and taught good nutritional practices. They encouraged parents to provide a nurturant, stimulating environment for infant development by emphasizing the importance of understanding and responding to the infant's needs.

The Farmworker Population

The Fair Start Program was developed to serve two communities of migrant families, farmworker camps located in the midst of tomato fields 5-7 miles outside the town of Homestead. The migrant families treat Florida as a home base, returning there from the northern harvesting season in November and remaining in the area until April or May. Each time the family returns, however, they must find new housing and begin again to establish eligibility for local public services. Many families, especially those with school-aged children, attempt to remain in the area through the summer, getting by on odd jobs because there is no summer work for farmworkers in Florida. Approximately half the families in the camps migrate in any given season.

The families served by the Fair Start program came to this country from Mexico either directly or one generation ago, often entering as illegal immigrants. In the U.S., they face poverty, poor health, economic instability, and unsanitary living conditions. Housing conditions in the camps leave much to be desired, one camp offers cinder-block duplexes, while

the other is a cluster of aging trailers on a treeless slab of concrete, most lacking screens and telephones. Farmwork is day labor, offering no stability, no benefits, no sick pay or health insurance -- for the farmworker, a day at the clinic is a day without work and without pay. At the same time, risks to health surround the farmworkers; in the fields they seldom have access to clean water or lavatory facilities, and pesticides pose a constant danger.

Beyond the poor living conditions, migrant life brings many stressors: language barriers and fear of the Immigration and Naturalization Service prevent many from seeking services, not only public assistance but even health care. Regular migration continually disrupts informal support systems and ties to formal institutions. This is how the nurse who directed the Fair Start Program described the challenge of serving a migrant population:

> Maybe half tell us they're going, the others just disappear over a weekend and never show up for their next visit. They leave, and in the process their clinic card gets outdated, and when they get back they're living in a new place. They need a new clinic card and can't get one till they have 3 or 4 weekly pay envelopes. So they are back in the area a month before they even get seen again for health care, and you've lost track of everything that happened while they were gone.

Public services are especially important to migrants and settled farmworkers who lack the supports provided to other Americans by their employers and communities, but these services must be designed to respond to the special problems faced by farmworkers: transiency, alien status, language barriers, and the isolation that results from these.

The Fair Start Program

The Fair Start program was launched in 1983 under the auspices of a farmworker organization providing childcare (the Redlands Christian Migrant

Association), and was transferred to the local primary health care clinic where it operated from 1985 to 1987. The purpose of the program was to reach out to the farmworker families using home visits to educate them about pregnancy, childbirth, nutrition, and child development, and to encourage the use of preventive health care services. The home visits began in pregnancy and continued through the infant's first year: 5 visits were planned for the prenatal period, 3 more during the postpartum weeks, and final 4 were to be scheduled during the infant's first year of life. The visits were conducted by four paraprofessionals chosen from the migrant population, who recruited and visited approximately 15 to 20 families apiece. The visitors were trained by their nurse-supervisors to recognize simple illnesses in pregnancy and early childhood, to suggest measures to alleviate discomfort, to encourage breastfeeding and family planning, to teach child development and safety, and to support the families in a myriad of other ways (making phone calls, interpreting letters, providing rides to the clinic, helping secure needed services).

The four Fair Start home visitors resembled the women the program intended to serve: they were Mexican or Mexican-American women from 21 to 30 years of age who lived in or had recently moved out of the two farmworker camps targeted for the program. All had completed 12th grade or obtained a GED, and three had previously worked in the migrant childcare program. They had 5 weeks of preservice training on health and health care, supplemented by a summer session on child development and by weekly training meetings.

During the two years of program operations covered by this evaluation, 117 pregnant women from the two migrant camps were enrolled in the program. Initially, most were recruited through door-to-door canvassing, but the home visitors later relied on word-of-mouth and serendipitous contacts in the

camps to lead them to newly pregnant women. The program participants averaged 23 years of age, and had completed a mean of 7 years of education. Most (77%) were married, and only 28% were primiparas, in fact this was the third pregnancy for the average participant. All were Hispanic, 64% born in Mexicon and 30% born in the U.S. During the prior year, 45% had followed the migrant stream north, while others stayed through the winter.

Only one woman declined to participate in the program, though eight more dropped out before they gave birth, and another 26 mothers left the program before their child reached 1 year of age. On average, the women received 4 educational visits in the prenatal period, another 4 postnatally, and 4 "general" visits of a more social or crisis nature.

Several lessons were learned over the four years that the program operated. The home visitors were able to reach women relatively early in their pregnancies (the average gestation at enrollment was 21 weeks), but they found it hard to schedule visits after the baby was 2 months old, since most mothers returned to work in the fields. Flexible scheduling, including briefer chats and weekend or after-dinner visits, was essential to maintaining contact later in the infant's first year of life.

The program was designed to have a dual focus on health and child development, but over time the emphasis fell strongly on health matters. The home visitors were trained and supervised by nurses, and the program's clinic affiliation influenced them considerably -- they enjoyed being seen as part of the health care system. In addition, the farmworker home visitors were somewhat resistent to the program's childrearing messages. They came from traditional backgrounds and were probably not themselves convinced that infants can learn and that they benefit from free activity and exploration.

Finally, it was harder than anticipated to protect the integrity of the program within the clinic. This primary care clinic was understaffed and overworked, straining to serve the indigent, uninsured farmworker population. The educational and supportive home visiting program was seen by some clinic staff as a luxury, and the home visitors were drawn into assisting with routine clinic operations. Later, small offices were created for the program out in each of the two camps, so the visitors spent all their time in the community. From there the home visiting program operated much more successfully.

Evaluation Design

The evaluation strategy was to implement a quasi-experimental design using the best comparison group that could be identified in these small, defined communities. The comparison group included 29 local women who had not been invited to join the program; these women were interviewed and their children were observed and tested. The comparison group also included an "archival" group of 36 Hispanic farmworker clinic-users who gave birth during the year before the Fair Start program was initiated. Only information from clinic records was available for these cases. The groups were roughly comparable in demographic characteristics (see Table 1), though the comparison mothers were over two years older, on average, and had larger families. The results presented here hold even when mother's age is controlled.

This is not an easy population to research, however. The clinic's medical records were reviewed to measure the use of preventive health care services by families in the program and comparison groups, and to determine the status of the infants at birth. Efforts to gather additional information on parent-child interaction and infant development were

abandoned because it was too difficult to find women and children at home for the researcher's visit. As a result, most is known about the success of the program's effort to increase the use of preventive health care, though even the clinic records often did not have complete data, especially on health care through the infant's first year of life. Consequently, the sample sizes for the comparisons reported here vary from 42 to 108 program cases and from 25 to 60 comparison cases.

Results

The initial goal of the Fair Start Program was to see that pregnant women began prenatal care at the clinic as soon as possible. Table 2 shows a trend indicating that the program succeeded in this effort: program mothers went to the clinic to have their pregnancies confirmed two and a half weeks before the comparison group ($p<.10$). However, they received no more prenatal checkups. Further exploration revealed that the clinic's appointment system was not responding to the Fair Start mothers' early pregnancy tests; those women simply faced a longer delay between the pregnancy test and their first appointment with a physician (nearly 5 weeks vs. 3 weeks for the comparison group). The overtaxed clinic was not able to bring in its prenatal patients for checkups until 24 weeks gestation. This finding stands as a reminder that the use of health care is jointly determined by the actions of individuals and by the institutional structures they confront.

Not surprisingly, the program had no influence on birth weight (see Table 3). In fact, the infants born to program mothers were smaller than those born in the comparison group ($p<.01$), but both groups were on the average healthy and good-sized, with mean birth weights of 7 lb. 5 oz. and

7 lb. 14 oz. respectively. In the entire sample, there were only 3 low-weight births.

Table 4 shows the results relating to the use of preventive child health care, results that corroborate the small difference the program made in the timing of prenatal care. Mothers in the Fair Start Program brought their infants in for immunizations more promptly, so that by 12 months of age, 63% of the program infants had received 3 DPT shots, compared with only 30% of the comparison group ($p<.01$). The program infants had more well-child checkups ($p<.01$) during the first year, and they were less often brought to the emergency room ($p<.01$). Clearly, the encouragement and assistance offered by the program were an effective means of increasing the mother's appropriate use of health care.

Finally, the program also addressed the topic of family planning, since the close spacing of births in farmworker families can pose problems both in perinatal health and in child development (the average program mother was bearing her third child at 23 years of age). In this area, also, the program had a notable impact. Clinic records showed that by 8 weeks postpartum, 68% of the program mothers had consulted on family planning methods, vs. only 45% of the comparison mothers, a contrast that only became stronger by 12 months postpartum. It follows that only half as many of the program group as of the comparison mothers had experienced another pregnancy by the infant's first birthday (12% vs. 28%).

Clearly, these results show that a home-based intervention delivered by peer paraprofessionals can have a positive impact on the health behaviors of a migrant farmworker population. Farmworkers face many health risks, and many barriers prevent them from using health care services (eligibility requirements, appointment policies, lack of access to transportation or a telephone, unfamiliarity with English, and the loss of income that results

when they leave the fields to go to the clinic). Outreach can help this population -- even four local women trained to make visits, become known, offer assistance, and simply be available, were able to unlock doors for their neighbors while they taught and supported them. This is a difficult population to maintain contact with, but a flexible program focused on the pregnancy and postnatal period clearly can benefit both migrant families and the clinics that serve them.

Table 1

Background Characteristics of Families in Research Sample

	Program Mothers (n=108)	Comparison Mothers (n=60)	signif.
Mother's age	22.9 years	25.5 years	p<.05
Mother's education	7.0 years	7.3 years	
	(n=108)	(n=29)	
Previous births	2.1 births	3.2 births	p<.05
% Married	70%	72%	
% Born in Mexico	70%	64%	
% Who migrated last season	46%	46%	

Table 2

Use of Prenatal Health Care

	Program Mothers (n=108)	Comparison Mothers (n=60)	signif.
Onset of prenatal care	19.5 weeks	22.1 weeks	p<.10
% Starting in third trimester	13%	21%	
Number of prenatal exams	7.8 visits	7.7 visits	
First appointment with M.D.	24.4 weeks	25.2 weeks	
Lag between pregnancy test and M.D. appointment	4.9 weeks	3.1 weeks	

Table 3

Infant Status at Birth

	Program Mothers (n=81)	Comparison Mothers (n=55)	signif.
Gestational age	39.6 weeks	39.7 weeks	
% Premature	4%	2%	
Birth weight	117 ounces	126 ounces	p<.01
% Low birth weight	3%	0%	

Table 4

Use of Preventive Pediatric Health Care

	Program Mothers (n=60)	Comparison Mothers (n=46)	signif.
Age at first DPT shot	14 weeks	18 weeks	
% With 2 DPT shots by 6 mo.	48	32%	
% with 3 DPT shots by 12 mo.	63%	30%	p<.01
Well-child visits by 12 mo.	2.8 visits	1.9 visits	p<.01
% With no well-child visits	6%	19%	
Emergency room use by 12 mo.	0.0 visits	1.2 visits	p<.01
% Using emergency room	4%	28%	

Table 5

Family Planning Practices

	Program Mothers (n=76)	Comparison Mothers (n=53)	signif.
% Consulted on family planning by 8 weeks postpartum	68%	45%	p<.05
% Consulted on family planning by 12 months	82% (n=42)	56% (n=25)	p<.01
% With another pregnancy by 12 months postpartum	12%	28%	p<.10

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